Petrie Advanced Dental

HEALTH QUESTIONNAIRE

Patient Name:_____ Birthdate: _____

CURRENT MEDICATIONS

1. _____
2. _____
3. _____
4. _____
5. _____

MEDICAL CONDITIONS

1._____
2._____
3._____
4._____
5._____

ALLERGIES

_____

_____

_____

_____

SURGERIES/HOSPITALIZATIONS

_____

_____

_____

_____

Reason for Visit: _____

Are you under the care of a physician: Yes □ No □ If Yes, specific condition being treated: _____

_____

Are you in Good Health Yes □ No □

Have you been hospitalized for severe illness? If yes what? _____

Have you been told you need to take an antibiotic prior to dental treatment? Yes □ No □

I CERTIFY THAT THE ABOVE IS CORRECT TO THE BEST OF MY KNOWLEDGE

_____ _____ _____

Signature Print Name Date